VOL. 13, NO. 2 JULY-AUGUST, 1963

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

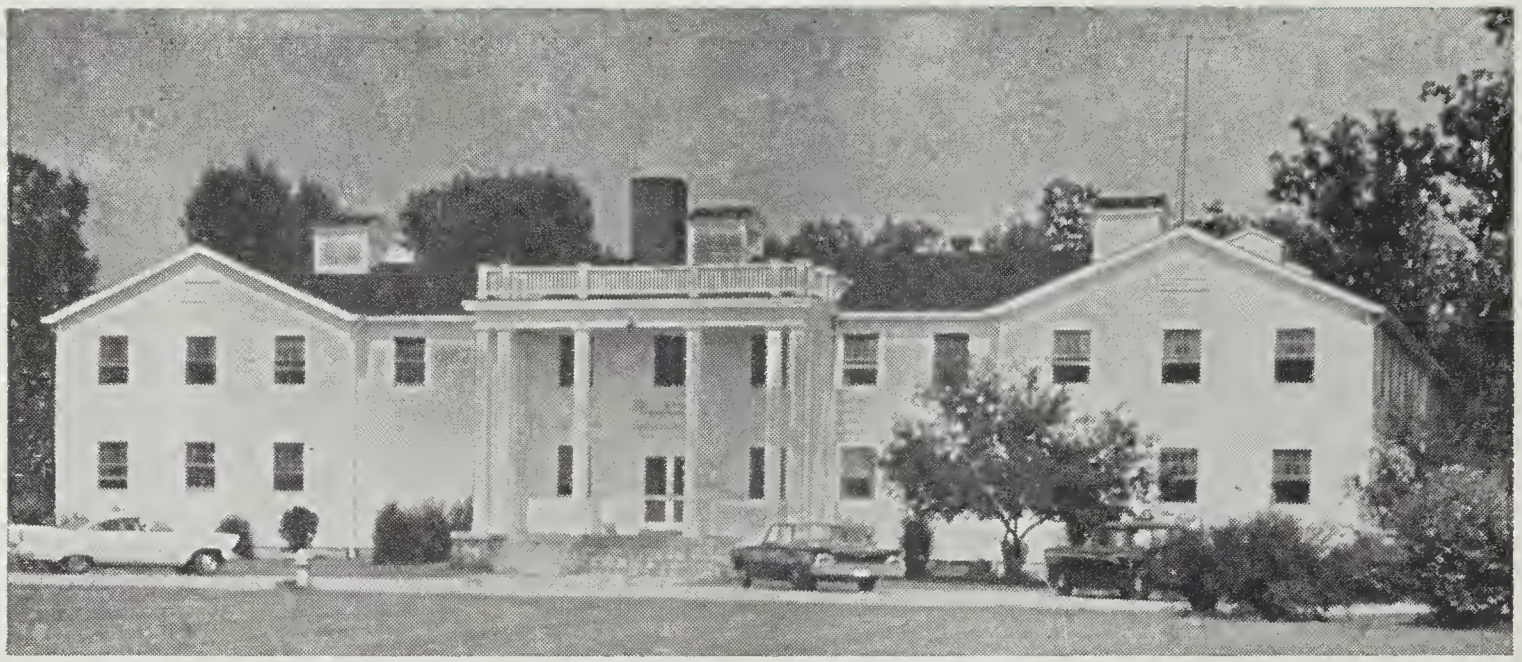
TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER



BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The Center is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Department of Mental Health. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay if the patient is able to pay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the medical director, a psychiatric social worker, a chaplain and admitting officer, a vocational rehabilitation counselor, an activities director, and a full attendant staff.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment in response to written or telephone request to the Medical Director of the Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment. All appointments must be confirmed by mail and should preferably be made by the patient's physician or by other professional personnel in the patient's community, for example, alcoholism information center personnel.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Services Agency, and a complete medical history, compiled by the patient's family physician, are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission if the patient is able.

4. Sign a letter-statement requesting voluntary admission at the time of admission.

It is especially important that patients applying for admission have a thorough medical examination and be in good physical condition at the time of their admission. The Center is not a hospital or a sobering up facility and patients desiring admission should have been sober for at least seventy-two hours and should not be exhibiting withdrawal symptoms. There are no facilities provided at the Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission. inasmuch as sleeping quarters are on the second floor.

Admitting Hours

Wednesday, Thursday and Friday during the morning and afternoon. Patients may have visitors after they've been at the Center for 2 weeks. Visiting hours are from 1:00 - 4:00 P. M. on Saturday and Sunday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

NORBERT L. KELLY, Ph.D.
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INVENTORY

VOLUME 13 NUMBER 2

JULY-AUGUST

RALEIGH, N. C.

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UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

Some alcoholics are sicker than others.

HELPLESS . . . BUT NOT HOPELESS

Some are not ready for treatment yet.

BY RICHARD H. WHITTEMORE

COUNSELOR, DIVISION OF ALCOHOLIC REHABILITATION
MAINE DEPARTMENT OF HEALTH AND WELFARE
AUGUSTA, MAINE

PROFESSIONAL and non-professional alcoholic rehabilitation workers from time to time wonder why some alcoholics recover rapidly, some slowly and painfully, and why others progressively get sicker. Yet all are exposed to the same techniques and personnel. At times one is tempted to say "many are hopeless." But when we examine our records we can find many recovered or recovering alcoholics whom we had mentally classified as "hopeless." Shouldn't we regard *all* alcoholics as temporarily *helpless* rather than *hopeless?*

I would like to describe this challenging group of problem drinkers who do not *seem* to respond to our alcoholic rehabilitation treatment techniques. In simple terms, I believe this group can be broken down into three categories, all of which include men and women of various ages, faiths, ethnic backgrounds, educational opportunities and "social levels:"

1) Those persons who have deep and serious mental and emotional illnesses for which their excessive drinking patterns are but a symptom. (It is questionable as to how many in this category can be classified as "full-fledged alcoholics.")

2) Those persons who are extremely sensitive and immature in a world filled with "cruel people, tough problems and unpleasant obligations." In this category we find a group of typical but sicker alcoholics.

3) Those persons who are not sick enough; who have not suffered enough; who are not ready to accept treatment. They firmly believe they have control over their use of alcohol. They don't want to give up drinking in spite of the problems that are starting to plague them.

In all three categories we re-

cognize one common denominator: All are using alcohol to excess, in various forms, as a drug—not as a beverage. They drink to escape pain—inner and outer and unidentified. Their motives for coming to an alcoholic rehabilitation center all differ.

In the first category we find many sick people who benefit little from outpatient counseling and group therapy. When these patients do not respond, and deeper mental and emotional problems are recognized, we refer them to psychiatric treatment or to a mental hospital or institution for longer term inpatient treatment. If he or she refuses, the family is made aware of its responsibility in the matter. Those who do complete treatment in mental hospitals are encouraged to continue with outpatient therapy at our centers. However, there are always those few incurable psychopaths who never learn from experience, and there are those, too, with permanent brain damage. But as stated in chapter five of the book *Alcoholics Anonymous*: "Their chances are less than average" . . . "but many of them do recover if they have the capacity to be honest." Even though everything humanly possible fails in treating a problem d r i n k e r, whether his pattern be excessive, addictive, steady or periodic, regardless of the seriousness of cause and diagnosis, we must never rule out the possibility of recovery through "a spiritual awakening" . . . rare, but very real. Experience, understanding, patience and hope are our most valuable tools in working with this helpless type of problem drinker.

In the second category we have "unruly children" running loose without guardians. They eat too many green apples and too much candy because they are undisciplined. In spite of the "tummy aches" they behave this way because they enjoy stealing, lying, overindulging, breaking rules, and boasting about all of this. They are rebels concerned only with their own selfish pleasures and desires.

But usually we are dealing with m e n and w o m e n over twenty-one; human beings unprepared for adult responsibilities, incapable of facing life's problems, and unwilling to conform to society's image of adult behavior. This brings on reprisal, embarrassment, dissolutionment, and anti-social behavior . . . drinking.

T h e s e extremely immature men and women innocently begin to use alcohol as a "magic potion" either to help them grow up and act like adults, or to escape from reality entirely into their own world of fantasy. Only those with the metabolic toler-

(Continued on page 6)

What's brewing?

A feature designed to help you keep posted on developments in the field of alcoholism.

GREENVILLE, N. C.: The thirteenth Flynn Christian Fellowship House in North Carolina has recently opened in Greenville. Mr. Herman Wilem, who has operated Flynn homes in Charlotte, Durham and Richmond, is serving as manager of the new Greenville facility.

RALEIGH, N. C.: Summer studies on "Facts About Alcohol" are in full swing throughout North Carolina. Already completed are the sessions at East Carolina College, taught by NCARP associate director Dr. Norbert L. Kelly; and those at North Carolina College, taught by educational director George H. Adams. Currently in progress are the courses at the Buncombe County Industrial Education Center in Asheville, which is being held in conjunction with Western Carolina College; and Winston-Salem Teachers College. Upcoming is the school at St. Andrews Presbyterian College in which Dr. Kelly and Mr. Adams will both participate. The summer studies course on "Facts About Alcohol" is sponsored by the NCARP and the various community colleges.

OLYMPIA, WASHINGTON: According to the Washington State Health Department, alcoholism caused twice as many deaths in the state of Washington in 1962 as tuberculosis, polio, measles and diphtheria combined. The department said that 107 deaths were due directly to alcoholism and 88 deaths were attributed to cirrhosis of the liver with some mention of alcoholism. Highway deaths caused by drunken drivers were not included in the figures.

SOUTHERN PINES, N. C.: The new Moore County Mental Health Clinic officially opened its doors on July 1. According to Dr. Charles Phillips, chairman of the board of directors, the demand for its services already far exceeds expectations. The staff of the clinic includes a psychiatrist-clinical director, an administrative director-psychiatric social worker and a secretary-receptionist. A visiting psychologist may later be added to the staff.

A number of patients will be referred to the clinic by the county health and welfare departments, the Moore County Alcoholic Education Committee, the North Carolina Alcoholic Rehabilitation Center at Butner, the state hospitals, physicians, ministers and school authorities. Patients applying directly to the clinic will be screened by the psychiatric social worker to distinguish what type of help is needed and if it is among those provided by the clinic.

The Moore County Clinic represents the culmination of about seven years of work and planning by the Moore County Mental Health Association, which was founded in 1956-57 with a community clinic as its chief goal.

STANFORD UNIVERSITY, CALIFORNIA: Nevitt Sanford, Ph.D., executive director of the Cooperative Commission on Alcoholism, has revealed in a recent report of the 1961-62 activities of the Commission that an Encyclopedia of the Problems of Alcohol will be a major project of the organization. The encyclopedia is under the editorship of Dr. E. M. Jellinek, former director of the Yale Center of Alcohol Studies and now on the staff of the Commission. The encyclopedia will consist of a 20,000 word index and a separate glossary of 200-500 words. A sixty-man editorial board will edit approximately 600 articles totaling 1,500,000 words.

PINEHURST, N. C.: Members of Alcoholics Anonymous groups throughout the state will gather together at the Carolina Hotel in Pinehurst September 20-22 for the 1963 North Carolina state AA convention. Speakers from North and South Carolina, New York, Michigan and Florida will appear on the program of the three-day meeting.

BERKELEY, CALIFORNIA: Two psychiatrists speaking at the second session of the California School on Alcoholism at the University of California believe that the United States is becoming more and more alcoholic. Dr. Hardin B. Jones, assistant director of the University's Donner Laboratory, said the U. S. now consumes 160 million gallons of spirits a year—plus 90 million barrels of beer and 150 million gallons of wine. He estimated that this was enough for every adult in the nation to down 2.6 gallons of 100 proof alcohol a year. Dr. Karl Bowman, professor emeritus of psychiatry at Langley Porter Clinic in San Francisco, estimated the cost of this liquor at $10.5 billion a year.

RALEIGH, N. C.: During the 1962-63 school year, approximately 150 requests from high school and college students for information on alcohol and alcoholism have been received by the NCARP. Students in North Carolina desiring information in the future should address their requests to the NCARP, Box 9494, Raleigh.

CAMP CAROLINE, N. C.: The annual Alcoholics Anonymous family retreat was held July 12-14 at Camp Caroline, located about thirty miles below New Bern. Members of AA and their immediate families enjoyed the usual good fellowship, relaxation and recreation that is always part of AA retreats.

SALISBURY, N. C.: A workshop on alcohol's effect on society was held July 8-19 at Catawba College in Salisbury. The workshop was designed for law enforcement officers, social and public health workers, and teachers. Included in the curriculum were the nature and extent of problems related to the use of alcohol, personality development, drinking and driving, the causes and treatment of alcoholism, the N. C. Alcoholic Rehabilitation Program, alcoholic beverages and narcotics. Consisting of ten three-hour sessions, the workshop offered two hours of academic credit. Fifteen full tuition scholarships were awarded to Rowan County public school teachers, law enforcement officers, social and public health workers, and persons planning to teach in Rowan County public schools the coming school year. The workshop was planned and conducted by the Rowan County ABC Board's department of education, headed by Peter P. Cooper, and by personnel from Catawba College and the N. C. Alcoholic Rehabilitation Program.

HELPLESS . . . NOT HOPELESS

CONTINUED FROM PAGE 3

ance for, and the emotional satisfaction from, alcohol succeed in becoming alcoholics.

After years of excessive use these people become addicted to, and completely dependent upon, the use of alcohol in various forms. When they appear for treatment they have very little courage, incentive or strength for the uphill road to recovery. If a few weeks of sobriety do not pay immediate dividends according to their expectations, they become easily discouraged, and with a "good alibi," run for the bottle.

A great many included in this second category of tough cases have no real purpose in life. They have not found a reason for existing. They feel they have little to offer, no service to perform . . . no causes to champion. After years of drinking they reach a stage of "suspended vegetation" on a cloud of liquid spirits. Without motive there is no purpose; without purpose there is no action; without action there is no recovery.

Alcoholics Anonymous has had some success with this type by providing a purpose and a society to fit their needs. In A. A. groups alcoholics can find acceptance and a chance to be of service to others they can understand, but many of them will not affiliate with A. A.

One could go on and on in detail about those in this second category because they are the most frustrating to a counselor and, at the same time, the most challenging. This group is helpless, but far from hopeless. Almost overnight their attitudes can change. Because, like little children, they are impressed by example, enthused as easily as they are disappointed. During every period of sobriety they grow up just a little more.

Time, patience and sobriety can level them off. On the other hand, such things as a love affair or sudden wealth can cause a relapse. No matter how often they slip they must be encouraged to try again. They need constant reassurance and guidance, and the association of recovered alcoholics. When in distress, they must feel free to come to the counselor for private consulation.

Naturally, we look for and find the guilt and inferiority complexes in group two. And there is always the risk in both groups one and two of a few becoming institutionalized if they are the type who adjust well to hospital or jail routines. Shut off from temptation in a world that provides for their basic needs, they find protection, acceptance and relaxation. They make friends easily and receive special treatment from the keepers or attendants. When they view confinement not as punishment, but as a gift from society, they will accept it in preference to "the struggle." Here they cannot fail.

These first two groups also produce those with sex deviations, frustrations and obsessions. In the first group we find the nymphomaniacs and homosexuals. The second group becomes more complicated as their problems are well hidden. But we detect in some latent homosexuality, masturbation guilt, drives for sexual security on any level, obsessions to prove virility, the pride in domination and conquest, the desire for the thrill of new sex experiences which serve as a temporary euphoric, and the seeking of acceptance and affection in sexual relations. Then there are the timid ones who find only rejection and frustration.

Those in group two seldom use reason. They can only live with themselves by rationalizing. For them alcohol releases inhibitions,

provides excuses for anti-social behavior, and drugs the conscience. Sobriety is not easily gained or accepted. They are very sick people.

We must not allow those in category three to upset the programs and techniques we have used successfully with the other types of problem drinkers and alcoholics. This group is just not ready to give up the bottle or to accept treatment for a habit. They are a selfish, carefree, deceitful, troublesome lot; inflated with ego and self-importance; stubborn, headstrong, and determined to have their own way. They believe they are not alcoholics and they resent being referred to as such.

These men and women enjoy everything about drinking. Without a drink in their hands they have little face, character or identity. When drinking they are ten feet tall. They like the camaraderie, the bottles, the glasses, the ice, the mixers, the noise and confusion. They don't enjoy drinking alone. They must have an audience.

Perhaps these indictments seem a little strong, but we are dealing here with people who are strong in their desires and convictions. They suffer from a warped sense of values, have great limitations, and misconceived opinions of society in general. Many are brilliant professional men and women. Some have no financial worries, and those who do won't admit it because the ego says they will soon be on top. These problem drinkers do not believe they are alcoholics "because I can stop drinking whenever I want to. I just don't want to." They cannot identify themselves with other alcoholics, drunk or sober.

Persons in this group enter our rehabilitation centers only under pressure from home, the employer, or the courts. Very few listen, or are willing to learn or try. Most of them spend their time trying to convince us that they are not alcoholics, that they have been misunderstood and abused; that they are too busy and too important to even be in a rehabilitation center; that they admire our work and can see the good in it for others. Need I go further in describing this type?

We must admit that we have very few scientific facts about the ramifications of alcoholism and the alcoholic personality. But it seems to be generally accepted that alcoholism is a progressive disease. Thus, if we practice tolerance and patience, show a little sympathy and understanding; sow a few seeds of information, and make a few constructive recommendations, we may get the chance in later years to really help these people when they are ready to surrender.

In conclusion, I would say that roughly half of those men and women who enter our alcoholic rehabilitation centers, clinics, or counseling offices, fall within the three categories herein described in brief, general tearms. The "alcohologist" still searches for words to describe causes, symptoms, types and techniques in this relatively new field of social and/or public health work. The other fifty percent of excessive drinkers not discussed in this article are sick, too, but they are much more receptive and cooperative and are sincerely willing to try to overcome their problems with guidance. Through counseling, group therapy, the fellowship of Alcoholics Anonymous, or a combination thereof, their cases are much improved, or arrested altogether.

I have seen enough so called "hopeless alcoholics" recover by one means or another to indicate to me that in our work there should never be a file marked "Hopeless."

Helpful to Minister

I would be most appreciative if you would place my name on your mailing list to receive *Inventory*. Your publication is invaluable to a layman like myself. The issues I have read are highly instructive in the practical art of treating and understanding the alcoholic patient.

Rev. Jack B. Yarbrough
Oak Grove Methodist Church
Mocksville, N. C.

Nurse Writes

I picked up a copy of your magazine in my doctor's office and was very interested in it. Because I believe my husband to be an alcoholic, or at least on the verge of alcoholism, I would like to be placed on your mailing list. I am a nurse but I feel there is a lot more I could learn about alcoholism.

Anonymous
Swepsonville, N. C.

Works With Alcoholics

As a counseling pastor who finds a large part of his work associated with alcoholics or their families, I believe that the publication *Inventory* would be of help to me. May I be added to your mailing list?

Reverend Albert L. Cardwell
Sherwood Baptist Church
Albany, Georgia

Comments on Article

I have just read the article, "The Alcoholic—Patient or Offender?", by Thomas Jones, M.D., and it is the most conclusive article I have ever read on alcoholism. I would like to have a dozen copies of this article. I am the chairman of the local Al-Anon group and need these to use in our work.

Anonymous
Elon College, N. C.

Appreciation Expressed

I'm so grateful to be still "eligible" to receive your marvelous publication. As an AA member here, I give many talks to church and school groups and your variety of approaches in excellent articles is so valuable to me! When we retire, I hope my husband and I can spend some time in your forward-looking state.

Anonymous
Detroit, Michigan

Thanks From Missionary

This is just to thank you for your magazine and to tell you how much I appreciate it. I didn't dream that I might be a missionary in Brazil when I accepted an NCARP scholarship to the Yale Summer School of Alcohol Studies in 1958, but alcoholism is a problem everywhere and I expect to try to help what little I can with it here. I hope to use the knowledge I received at Yale and through your fine magazine to be a small part in an "N. C. Point Four" program here, for just as my duties as pastor in the U. S. kept me constantly in touch with this problem, I expect they will here, too. Thanks to the information of your journal I've been able to send for information about Brazil and alcoholism to the Rutgers Summer School of Alcohol Studies, for I found their address here.

Rev. George C. Megill
Est. de Sao Paulo, Brazil

ALCOHOL AND *Your* BRAIN

MOST of the readers of this magazine have personally and quite thoroughly explored this subject.

Alcohol—the "mockingbird" among drugs—changes its effect with the dose. For those who drink so slowly that they do not feel their drinks at all, admittedly a small group, alcohol acts merely as a beverage with no drug effect. If they drink a little more or a little faster to produce a slight rise in alcohol level, they obtain a "tranquilizer" effect. Some authorities still maintain that, in spite of all its dangers, alcohol is both the oldest and the safest of the tranquilizers.

By drinking still faster, the drug effect is increased to the "sedative" level. Although dangerous, the sedative dose is very popular since it reduces tension, lowers inhibitions and generally makes one "feel good." For many, these assets outweigh the liability of disturbed judgment.

BY R. G. BELL, M.D.

Reprinted by permission, this article was originally published in the March, 1963 issue of the *AA Grapevine*.

Alcohol can play the role of tranquilizer, sedative or anesthetic. Whether or not problem drinking develops is largely determined by the way individuals use alcohol.

"Some human brains can take much more anesthetic than others."

Alcohol can do much more than this. By exploring still higher levels, a "painkiller Zombie" result can be produced that is truly impressive. The old expression "feeling no pain" didn't occur by accident, even though there are better drugs for the purpose.

Finally, by "going all out," a true "anesthetic" effect with unconsciousness is possible. This ether-like result usually completes the chemical adventures with alcohol. Those who explore the last step—the "breath stopper" effect—won't be reading this anyway.

Drinking to "feel your drinks" is drinking for a drug effect. Unfortunately, millions have found out the hard way that this kind of drinking cannot be carried on indefinitely with safety.

How do the brain and alcohol get along in the beginning? From the very start of drinking, or soon thereafter, many find it possible to get "high" without getting sick. That segment of the public who consistently get sick before they get high are not regular readers of this magazine. Some find that drinking can be enjoyed to the point of intoxication, even though "hangovers" are suffered the next morning. As their drinking continues, they are able to adapt to larger quantities of alcohol and the hangovers become milder.

There is a special group who believe they are among God's chosen; they neither get sick while drinking nor suffer from hangovers afterwards. A false feeling of confidence about ability to handle alcohol develops. Years later, when they start to shake whenever they try to stop drinking, they are naturally somewhat confused.

What we are saying, in effect, is this: some human brains can take much more anesthetic than others. For a time a member of this group is able to drink more than most without showing much effect. That high tolerance that remains for the first few years is actually a sign of danger rather than of safety, if they only knew it. When a person begins consistently to be affected by less alcohol, or to be affected in a new way, so that friends comment on the change—he is no longer the same kind of person when he drinks—that person's brain begins to signal that it can no longer cope with alcohol in the old way.

This change may include memory lapses or blackouts. Again the blackouts may exist with or without a Dr. Jekyll-Mr. Hyde change in personality. Whatever form the change takes, the drinker begins to realize that it is permanent. It has become a predictable part of drinking. Moreover, this change gradually but steadily appears to get worse. When talking to drinking friends it can be summed up by the statement, "I can't take it like I used to!" Somehow he can sense that there is no return to trouble-free drinking, however much the admission hurts.

The brain and nervous system, in conjunction with other parts of the body, can signal in another way that drinking is producing new trouble. Without alcohol, the drinker is so over-active, shaky and jumpy, that it becomes difficult to function. Each day has to begin with a treatment of this condition. Thus the morning drink becomes a daily ritual. At work, more ingenuity is required to

hide the smell of alcohol and to appear busy than was ever required for the job itself. When the stomach gives out, or the home situation erupts into open warfare, it becomes necessary to go through an abstinence reaction for a few days and "shake it out." Repeat this often enough and hallucinations, convulsions or delerium can be added to the "shakes."

What about the chronic drinker—the one who is able to drink a bottle a day for years without getting into serious trouble? In that case the brain and nervous system may suffer in another way altogether. There may be difficulty in remembering names and places, impairment in concentration, an inability to focus attention on one problem for very long at a time. Burning and tingling in the feet and hands, or some impairment in vision is often experienced. Some people even acquire a peculiar kind of squint. These are warning signs that malnutrition accompanies the chronic excessive use of alcohol and produces its own diseases.

Phases In Thinking

So far we have considered some of the more common changes in the brain produced by repeated intoxication from drug doses of alcohol or the accompanying malnutrition. (The additional changes in liver, stomach and pancreas are not discussed in this article.) This is only a small part of the whole story. No discussion of the brain and alcohol is complete unless we consider the phases in thinking throughout the experience of dependent drinking.

Before anyone has a first drink, alcohol is just a word with a meaning largely determined by the attitude and experience of the family. Since there is no personal knowledge of alcohol, the mind is not occupied with thoughts of what it might do. Unlike most drugs, the first contact with alcohol is not through medical prescription. Alcohol is used in the community for a great variety of personal or social reasons, and its first contact is usually determined by the particular type of drinking in that community. For example, if a family has very strict rules about drinking, considers drinking immoral, guilt may become part of a reaction to alcohol, from the first.

Whether or not trouble from drinking develops is largely determined by how many uses for alcohol are found. The dependent drinker is pleased that alcohol is so readily available and that his personal requirements can be at least partially met by social drinking occasions. Those who continue drinking harmful quantities of alcohol do so because they like the effects produced by these quantities. Used in this way, alcohol does things for them that are unique; nothing else that is swallowed provides such a welcome change in feeling—a temporary solution to such varied conditions as worry, frustration, shyness, loneliness and boredom.

A small group who use alcohol for its drug effects are unable from the very start to drink as much as they want without getting into some kind of trouble. Their need for alcohol and their physical tolerance are never in harmony. Larger and larger quantities must be used. During this early happy period there is naturally a lot of thinking about alcohol, since it has acquired more significance than anything else swallowed. This period in their lives, in which it is possible to drink as much as they want without serious physical or social repercussions, might be thought of as the "phase of contentment." It comes to a close with either the first physical warnings,

such as blackouts, the morning drink, liver disease, or by the first signs of trouble at home, on the job with the police. From now on reasons for drinking increase but ability to drink declines.

These early drinking problems introduce the "phase of concern" with a new element of worry added to the reasons for thinking about alcohol. A determination to find a new way to carry on drinking without trouble poses a challenge to resourcefulness and ingenuity—drinking away from home, changing brands, mixers, and the location, frequency, duration and regularity of drinking. Thus the "phase of concern" is one in which many changes in personal drinking habits are explored. The fact that permanent abstinence is not considered a solution at that time highlights the power of an unhealthy dependence on alcohol.

Since both physical and social problems continue to get worse, in spite of elaborate efforts to discover a safe way to drink, these people are forced onto the defensive. Although they have begun to appreciate that alcohol is now controlling them, they hate to admit it, even to themselves. This leads to a special kind of thinking characterized by alibis, lying, cover-up, resentment, s u s p i c i o n, blaming others, solitary drinking, protecting supply, and so on. Thus still more of the mind becomes occupied with thoughts of drinking or in defense of it. A steadily diminishing amount of attention can be given to home, job and community responsibilities. A progressive loss of mental freedom is experienced as minds become increasingly dominated by alcoholic thinking. In this phase the need for alcohol is so overwhelming that the thought of no alcohol produces more alarm than the danger of continued drinking.

Finally something occurs to make it temporarily less threatening, or more rewarding, to stop drinking than to continue. It becomes important to look for a new way of living that will not involve slavery to a drug. With the first indication of a break in the system of alibis the defensive drinker takes the first step on the road to recovery. He moves from the "phase of defensive thinking" to the "phase of acceptance or surrender." Unable to see a way out by his own efforts, he may, if he is one of the lucky ones, prepare to look for help.

If he chooses this path, his thinking moves into the "phase of recovery." Thoughts about alcohol do not stop simply because drinking stops. The mind which has been occupied with such thoughts for many years cannot change so quickly. In the early stages of recovery it is often necessary to be one's own mental policeman—to be on guard that the thought of drinking does not lead to the act of drinking. New methods of solving problems or alleviating unpleasant feelings must be found. During recovery he comes to realize that new living involves more than simply not drinking or swallowing something else whenever a change in feeling is desired. He learns that in time of need he does not depend on alcohol for its tranquilizing, sedative, pain-killer or anesthetic effect; neither does he seek any other substance that can produce these effects. Turning his back on this method, he replaces it by looking to others, to his own unused abilities and to a power greater than people altogether, when he needs help. As this process develops and produces its own rewards, there is more and more freedom from alcoholic thinking. Finally, alcohol is again only a word, but a word with all the additional meaning from prolonged and varied experience.

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ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

Providing our young people with accurate facts is not enough. We need to create an atmosphere in which they can frankly discuss their ideas and concerns about the use of alcohol.

WE shall attempt here to look at the ways which society uses and abuses alcoholic beverages for it is against this background that our young people formulate their attitude about drinking. And make no mistake about it; our young people are experimenting with drinking long before they leave school. A recent study in Nassau County, New York showed that 70% of their school children had at least sampled a drink by age 14; when the same group reached the tender age of 16, 90% of them had made this experiment. Studies in other sections of the country have revealed the same high interest and curiosity in drinking among youngsters. So our children are learning about the use of alcoholic beverages; what is it they are learning?

To arrive at this answer, I want to quickly survey the history of drinking patterns, especially as they have developed in America. So come with me as we cover 4,000 years of history in five minutes.

The Use and Misuse of Alcohol

BY THE REVEREND THOMAS L. SPITLER

PRESIDENT, COUNCIL ON ALCOHOLISM
OF THE
CINCINNATI AREA

Based on a talk given by the author at an Educator's Symposium in 1962.

Since the beginning of recorded history, man has known about alcoholic drinks and their effect. Primitive man knew how to make wine from grapes and other fruits. He knew also the effects too much wine produced and he attributed these effects to the presence of a god in his wine. Even in these early times, the society or tribe exercised controls upon the individual's drinking. While the men drank, the women stood by, ready to tie up anyone who became intoxicated. This precautionary measure prevented the individual from harming either himself or the tribe.

The Bible makes frequent reference to drinking. One 18th century commentator noted that "it is probable that the first men were not ignorant of the use of wine, which is a liquor so generally useful and agreeable that it could scarcely be unknown even to Adam himself." There is an ancient Hebrew myth regarding Noah's planting grape vines after the flood. When Satan asked him what he was doing, he replied, "I am planting a vineyard. When the fruit is ripe, the grapes are excellent to eat, either moist or dried. And when pressed, the juices become wine which warms the body and the spirit." Then Satan brought a sheep, a lion, a pig and a monkey. He killed them so that the blood of each animal flowed about the roots of the plants. This was understood by these ancient people as a sign that man, before drinking, is like a sheep—mild and inoffensive. When he begins to drink, he feels like a lion. If he drinks deeper, he begins to chatter aimlessly, scampering about like a witless monkey. If he drinks still more, then splattered with food and drink, he finally drops to the ground, wallowing in his own filth.

This myth illustrates the ancients' attitude toward drink: taken in small quantities, it can be pleasurable and good for the body; used to excess, it turns man into a senseless animal. Drinking was commonly practiced, but drunkenness was severely condemned.

The early settlers of America brought with them the drinking patterns of their former country. Although it was some time before they planted vineyards, their supply ships did bring them casks of beer and ale from England. The Puritans were a strict group, but they did permit drinking in the Massuchusetts Bay Colony. Drunkenness, however, was punished. It was not long before the local tavern appeared among the villages of the scattered colonies. The social status of the tavern keeper was considerably higher in those days than it is for his modern-day counterpart. He was the keeper of the village's morals. It was his responsibility to see that his patrons remained sober. Only a man of the best character could operate a tavern.

New Drinking Pattern

With the cessation of the Indian Wars, the western frontiers became safe for settlers and a great number of them poured through the Appalachian mountains into the great Northwest Territory. These settlers did not have room to pack along their beer, but they learned a new trick—the distillation of corn pressings into hard liquor. The widespread use of distillation among the pioneers introduced a new drinking pattern into American society. Whereas beer had an alcohol content of 6% and wine an alcohol content of 12%, it was now possible, through distillation, to produce a beverage containing 40 to 50% alcohol. The net result was a great increase in drunkenness. Whereas many people

previously could not afford to buy enough ale to produce intoxication, now a man could drink himself unconscious at little expense.

Apparently many men did just this, for we note the rise of the first temperance groups in America not long after the widespread use of hard liquor began. Dr. Benjamin Rush of Philadelphia, a signer of the Declaration of Independence, was among the first to advocate the use of temperance in the consumption of alcoholic beverages. Lyman Beecher, the noted New England divine, was another. These men were temperates in the true sense of the word. Their plea was for the controlled use of wine and beer so that drunkenness, harmful to society, could be avoided.

Prelude to Prohibition

It was not until 1840 that we find the beginnings of groups who condemned the use of alcohol in any form. These people possessed enormous zeal, as do most reformers. These advocates of abstinence not only campaigned vigorously for the elimination of alcoholic beverages but they were ardent supporters of many social reforms, including labor laws and regulations for the use of child workers. It was characteristic of these people that they believed fervently in social legislation to control the ills of society.

The Civil War momentarily halted this movement, but the latter years of the 19th century saw renewed efforts to banish all types of alcoholic drinks from the American scene. By the time of the First World War, statewide prohibition laws existed in 19 states, with 26 other states having local option laws on the statute books. The stage was set for nationwide prohibition, which became a law in 1920 with the passing of the 18th Amendment.

If you have watched Elliot Ness and his Untouchables, you know that prohibition brought more problems than it solved. By 1924, as many people were drinking as had drunk previous to prohibition. Worse still, the entire liquor industry, its manufacture and distribution, was underground and could not be controlled by laws. A wild period ensued during which the organized rackets appeared in the annals of American crime. The millions who did drink bootleg liquor were drinking liquor whose production was not controlled by the government. The "wildcat" liquor produced many harmful effects in the consumer. "Bathtub gin" blinded more than one partaker. National prohibition was repealed by the 21st Amendment in 1933.

Drinking patterns in modern America reflect a great deal of confusion on the part of those who do drink. These patterns indicate that many, many Americans have only vague ideas of why they drink. "It seems to be the thing to do," is a statement that sums up the attitude of a large segment of our drinking population. Our teen-agers are exposed to this uncertain attitude, and so their drinking habits and attitudes toward alcoholic beverages reflect this same confusion.

Let me illustrate what I mean by unstable and confused drinking patterns. For some years I lived in New England, in an area whose population contained a large percentage of Italian people. The drinking habits of these people present a sharp contrast to those of middle class Americans. My Italian friends often made their own wine. Papa would go to the market and buy a case of grapes. Then the whole family joined in making the wine. The Italian families use this wine almost daily at mealtime. They look upon it as a part of their regular diet. In the

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The Schools and ALCOHOL EDUCATION

Alcohol education in the school is an important addition to each student's personal equipment for living as a socially responsible adult.

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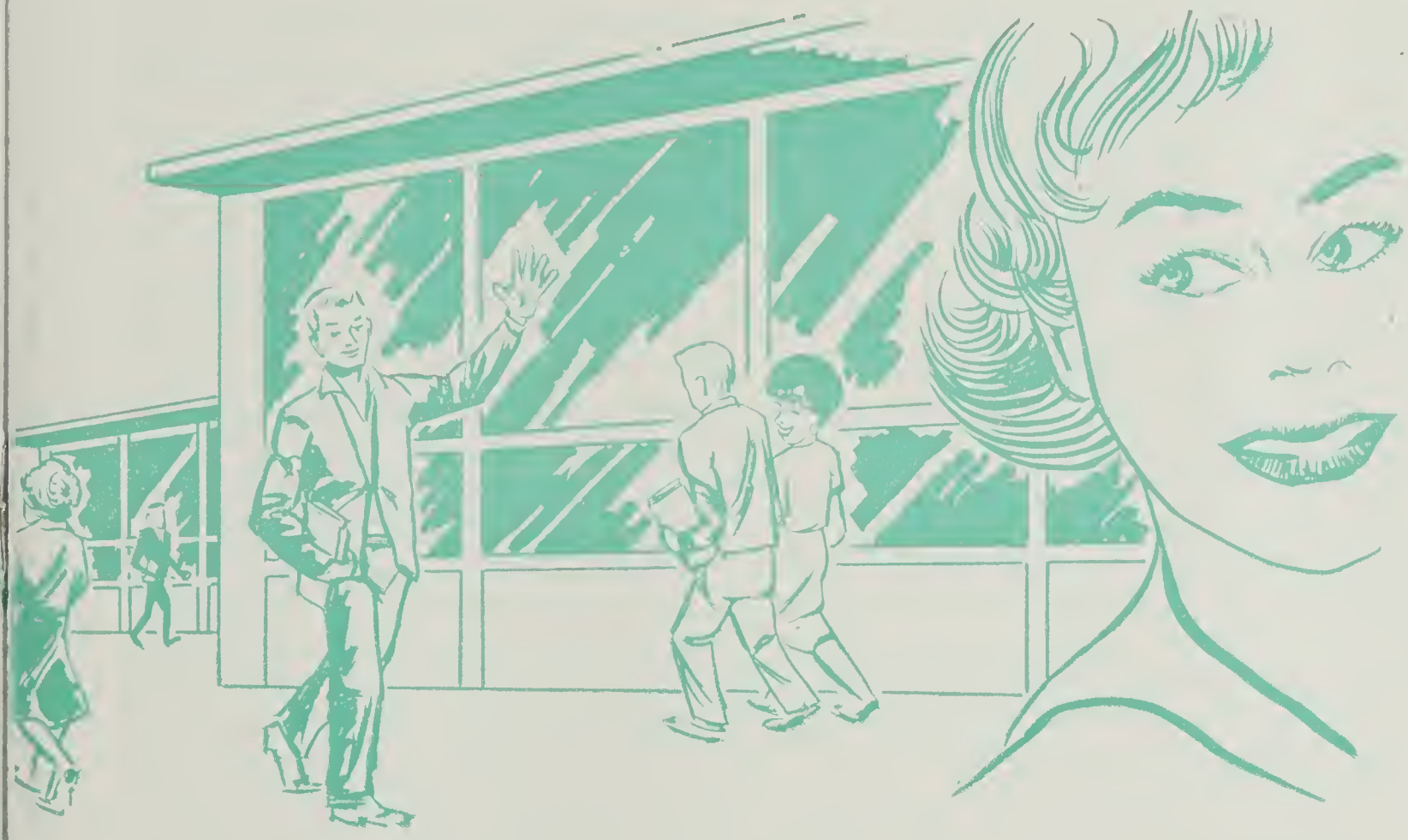
WHEN the World Health Organization sent a team of health workers into an under-developed country, it learned that it had to understand something about the culture in which the team was working. It concluded that there can be no standard pattern for a health education program that will work everywhere. This conclusion holds true for alcohol education programs which, if they exist, can and do vary within the same city, province or country. This implies that the teacher must consider many factors in planning a program of alcohol education in the school. Whether we like it or not, the school reflects the community; young people are quite aware to what extent alcohol is socially accepted or not accepted.

Do high school students drink? While there have been no scientific studies done in Canada, there have been 10 carefully conducted investigations to date bearing directly on teen-age drinking in the United States. Although we are all aware that our drinking habits are not the same as those of people in the United States, it is quite interesting to note that the pattern of drinking of American young people quite faithfully mirrors that of their elders. Drinking habits, in general, vary with national origin, family income, education and religious background, and these habits tend to be reflected in the children. Teen-agers are not isolated organisms; they are continually susceptible to the stresses and strains, to the pleasures and pains of the society in which they live.

The purpose of introducing the study of alcohol in the school is to provide an important addition to each student's personal equipment for living as a socially responsible and well informed adult. Decrease in the solidarity of the family group, changes in the economic status of families, and increased freedom for young people in social life, have all brought new and greater responsibilities to young people for directing their own behavior. Sound alcohol education will prepare young people for the decisions they will make as adults. Whether an individual eventual-



ly chooses to be a social drinker or an abstainer when he is old enough to drink legally is not the responsibility of the teacher. However, it is the teacher's responsibility to provide the factual background with which a student may intelligently choose the course that he considers appropriate for himself.

Young people are eventually going to make up their own minds whether or not to drink. Our studies indicate that the most influence will come from the parents, and secondly, from the group of friends to which the individual belongs. Ideally, young people should learn from their parents all that they need to know about alcohol; but it is evident from our files of patients in alcoholism clinics, and from reports of traffic accidents involving intoxication, that some parents are not adequate teachers or even good examples. So it becomes the responsibility of the school to supplement such instruction. There also seems to be an increasing number of parents who permit their children to taste or experiment with alcoholic beverages at home. While parents do warn of the danger in consuming, some seem to forget that personal example in health education against alcoholism is the most important education factor.

Alcoholism is a rare phenomenon among teen-agers in Ontario. In fact, of the close to 10,000 patients treated since 1950 by the Addiction Research Foundation, only a few teen-agers have been seen. However, the drinking histories of many patients reveal that these adult alcoholics began drinking in their teens. Dr. E. M. Jellinek, a world authority on alcoholism, testifying before the Bracken Commission in Manitoba in 1955, went even further. He said that one-third of the North Americans who later became alcoholics have their initial drinking experiences between the ages of 14 and 18, and between the ages of 18 and 21 they begin to show the prodromal or pre-disease signs of alcohol addiction.

So you can see that the question of teen-age drinking is important. It is also a question fraught with much exaggeration and alarm. So far in Canada, we

have had to rely on impression, conjecture, newspaper headlines, gossip, and a couple of inadequate surveys. We believe that under-age drinkers are in a minority among the high school population, and that an even smaller sub-minority of these illegal drinkers get into serious trouble as a result of their drinking. It is the nature of such trouble, however, to attract a great deal of notoriety to the young people concerned, and to the whole question of under-age drinking. I am not sure whether we can reach this sub-minority in the classroom, but we do have a sincere obligation to the many teenagers who are not involved in drinking situations and who need more information than they now have. We make sure our children are given the best protection against smallpox, polio, and tuberculosis. It is equally important to give them the full story of alcohol, its use and mal-use, as they enter social and business life.

One of the very important reasons why the efforts of the schools have failed to influence the drinking customs of the nation in the direction of abstinence is that they overlook the fact that drinking is a well established social custom which serves many needs for many people. The strength of the motivations which maintain this social custom must be taken into account. Probably no other area of study lends itself so well to the development of skills and insights into the problems of social living. High school students are making important decisions every day, decisions that will shape their roles as adults. These decisions include honesty, integrity, relations to the opposite sex, and the use or non-use of habit forming substances, to name but a few. Our job is to provide the students with established facts about alcohol and its use in our society. (There are appropriate as well as inappropriate uses of alcohol.)

In our presentation to the students, we would be remiss if we didn't point out how the church looks upon drinking. One of the factors affecting drinking attitudes and practices in Ontario, as elsewhere, is the influence of the churches. Some churches oppose drunkenness, but do not necessarily condemn the moderate social use of alcoholic beverages. Some churches use fermented wine in their ritual, while others use unfermented wine. Certainly, all churches are unanimous in their opposition to the "excessive" use of alcoholic beverages, but not all would agree to what is excessive. While we must keep in mind the fact that it is illegal to consume alcoholic beverages under the age of 21, the moral question—is it right or wrong to use alcohol?—is primarily a religious question, and I doubt the advisability of discussing this aspect in the classroom. In our democracy, with its freedom of religion, Baptists, Roman Catholics, Presbyterians, Anglicans, United Church members, and so on, are all Christians of equal worth.

Goals for Alcohol Education

What, then, are we going to teach? Who is going to teach it? At what grade level? In what subjects? How many periods?

A group of leading Ontario physical and health education teachers, who attended the Yale Summer School of Alcohol Studies, and who have given considerable thought to the whole subject, decided on two limited goals for alcohol education in the schools. These goals are outlined in the "Alcohol Studies Guide," prepared by the Alcoholism and Drug Addiction Research Foundation at the request of the Department of Education, for use by teachers of health and physical education. *Goal*

number one is to let students know that there are many different reasons for drinking or for abstaining from the use of alcoholic beverages; and that there are many different ways of using and regarding such beverages other than those seen in the students' own homes and among their own particular groups of friends. *Goal number two* is to make it clear that there are recognizably dangerous ways of drinking which affect people of all ages.

Let us begin with an appreciation of the way in which different groups of people in our population today view and use alcoholic beverages, people who have come to Canada from various European countries, who have brought with them their own traditions and tastes. As a result of these influences, our drinking customs are slowly changing in character and emphasis. This is not to say that all drinking by Europeans in Canada, or Europe for that matter, is innocuous and worthy of emulation. There is much alcoholism in Europe, there are many traffic accidents involving impaired driving, and there are undoubtedly other social and personal problems in which alcohol may be involved.

It becomes important within this first goal to briefly outline drinking and alcoholism in a number of countries, such as France, Italy, and the United States. In this summary, it becomes apparent that other factors than the rate of consumption or the type of beverage must be at work in the creation of the high or low rate of alcoholism among different peoples. It should also lay to rest the old chestnut that "all we have to do is learn to drink as they do in France." Generally speaking, in Canada there is a distinctly ambivalent attitude toward the use of alcoholic beverages, an attitude that seesaws this way and that, to the confusion of many young people as well as adults.

Also, I think we owe it to our students to take an objective look at how we, in Canada, do or do not drink. Our objective approach will consider the issues impersonally, unemotionally, and scientifically. It should help young people to understand the reasons why people use alcoholic beverages, give them accurate knowledge of the effects of these beverages on the body and on one's thinking and behavior, and help them to clarify the various social problems connected with the use of alcohol.

Patterns of Drinking

Now as to the second goal, if a student has decided to do some drinking, I believe that he needs the knowledge of which patterns may indicate the tendency towards alcoholism. Young people find it very difficult to see 15 or 20 years ahead and understand the implications of the term alcoholic. "It always happens to the other guy" is a common expression heard not only among the young but among the old as well. I like to point out to young people that most of our present alcoholics started out with this same kind of fallacious reasoning. While we can't predict who will become an alcoholic, we must assume that if they drink, they should be aware of the possibility of becoming one. Dr. R. Gordon Bell, a noted alcoholism specialist in Toronto, says, "I would go so far as to say that the dangers associated with the use of alcoholic beverages are so great that one should not use alcohol until there is sufficient understanding of drinking —an enlightened awareness."

In Ontario, alcohol education has been carried on by guidance, science and home economics teachers, but mainly by teachers of health and

physical education. It is my feeling that education about alcohol should be taught in a subject which is taken by all students, at all grade levels—and health and physical education is the most logical subject. Alcohol education can be fitted quite nicely into the present health course, and taught by a specialist in the health field.

Certainly, we must not underestimate the role of the teacher in this controversial area. My job as teacher training consultant for the Foundation is to travel throughout Ontario, meeting and conducting seminars with small groups of secondary school teachers, showing them our materials and suggesting ways in which the subject can be handled in the classroom. We also encourage teachers to attend the Foundation's annual two-week summer course on alcohol and problems of addiction. We have heard it said that ideally all teachers should teach about alcohol in all subjects as it relates to their particular subject. My own objection to this is that alcohol education requires special skills, special knowledge, and that it may become so integrated that one would have difficulty finding it.

Although Ontario's present course of study is under revision, I could safely say that alcohol education is now being taught mostly in grades 11 and 12. If we take a look at the average student drop-out figures over the past 10 years in Ontario, for every 100 students who enter grade 11, 51 will not reach grade 12; and 73 will not reach grade 13. Thus, it can be plainly seen that if we concentrate on the senior grades—11 and 12—then 43 per cent of the students who enter high school will leave without benefit of instruction in this important area. Since the student drop-out is minimal between grades eight and nine, I feel that we could safely start teaching about alcohol in the first year of high school, and this is our present goal in Ontario. If this be the case, we must not subject the same students to the same materials year after year as they progress through our school system.

I am quite aware that teachers have but limited time at their disposal, and many special interest subjects which demand attention. I would suggest that at the grade nine and ten level, two periods be used to give the students suitable information related to their age group. At the senior level, possibly four periods should be used, concentrating on the social aspect of the use or non-use of alcoholic beverages.

Coordinated Attack

I would like to suggest that alcohol education in the schools is not *the* answer to our problem, but it is one part of the answer. Alcohol education calls for an attack on a broad front, as well as the mobilization and coordination of all community resources. No one discipline, no one profession, no one organization, has the total answer. I think we, in the schools, have to work closely with these organizations and coordinate our attack. In Ontario, we encourage the students to take home our illustrated booklet, "It's Best to Know About Alcohol," for parents to read and digest. This has been an excellent entree into the homes and the community at large.

No one needs to remind us of the serious nature of the problems of alcohol in our society. Alcohol and its related problems are interwoven into the psychological and social issues and forces in our society—elements in which changes occur only slowly. The more I delve into this area, the more I am convinced that the true goal of prevention is in the

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"To handle an alcoholic husband, you must have expert help and guidance," says the wife of a recovered alcoholic.

BY AN ANONYMOUS WIFE
as told to
JIM POLING

I Saved My Husband From Alcoholism

Today, at least one out of every 20 families in North America is affected by the problem of alcoholism. In their efforts to understand and deal with this alarming situation, psychiatrists and experts on alcoholism have recently discovered a startling fact: Most wives of problem drinkers actually do their husbands more harm than good in their well-meant attempts to help them stop drinking. In fact, they often drive their husbands to drink more rather than less.

Because of this, we have a new approach to the problem of the drinking husband: First treat his wife. Psychiatrists help her to get rid of her unreasoning emotional reactions and give her a fresh insight into the problem. Once a wife knows how to act toward an alcoholic husband, the

job of helping him becomes easier. In effect, she opens the door for him.

My own story is a perfect example and I tell it only in the hope that it will show other alcoholics' wives the importance of seeking professional guidance. If my story helps even one despairing wife save her marriage, I'll be amply rewarded.

It took me eleven years of living with an alcoholic husband to find out that everything I was doing to try and help him was wrong. I was giving Steve the 'Home Treatment,' which is the ironical name psychiatrists have given the methods almost universally used by wives who are 'trying to bring their husbands to their senses.' These methods never work.

The Home Treatment is a compound of futile talk, weeping, and pleading. I thought I was talking to Steve with 'sweet reasonableness,' but I hate to think of the number of bitter rows that grew out of these so-called calm discussions.

Then I pounded him with meaningless emotional appeals: Don't you love me? Think of the children! Have you no self-respect? and so on, far into the night.

I tried coaxing, too, of course, and discovered that when you promise to do anything if your husband will give up drinking, you end up sobbing. So I turned to threats. I threatened to leave Steve on an average of about once a month.

And I did leave him a few times. But, because I loved him, I always returned as soon as he solemnly promised to stay sober. Nothing I did had any lasting effect on him. I poured his liquor down the sink, only to have him stalk angrily out for more. I persuaded our friends—as long as we had them—not to serve liquor to him at parties.

To spare him 'unnecessary worries' I took over as head of the family; managing the checking account when there was one, fighting off the creditors, even making the minor repairs around the house. When he suffered incapacitating hangovers, I called his office and lied to cover up for him. And still he drank.

It never once occurred to me that from Steve's point of view I was a nagging, preaching wife who went on and on at him until he had to go back to the bottle in self-defense. I was aggravating the very condition I was trying to cure.

By the end of 1957 I was desperate. Things were much worse than they'd been when Steve began drinking after his return from World War II. We were deeply in debt and his accountant's job was in jeopardy. What's worse, my nine-year-old Doug was so afraid of his father that he'd run sobbing from the house the moment Steve raised his voice.

Lonely Children

My fifteen-year-old Ann was different. When her father went into a drunken rage, she'd grab a poker or an iron skillet and lock herself in her room crying out, "If you dare touch me, I'll brain you." Both youngsters were failing in school, and they were both lonely, withdrawn creatures who'd never brought a playmate into the house.

I was a nervous wreck, living on coffee and cigarettes and bursting into hysterical tears on the slightest provocation. For the first time, I began to think seriously of a divorce.

Then came a turning point. On Christmas Eve, 1957, Steve didn't come home. The children and I went through the pitiful travesty of opening the presents under our small tree without him. He finally returned the morning of the 27th with four bottles cradled in his arms, fourteen cents left out of two weeks' salary and his year-end bonus, and in such

dreadful shape I had to have him hospitalized immediately. However, when he came out of the hospital he was so remorseful that, for once, he was willing to do anything I asked of him.

I arranged for him to see a psychiatrist. This lasted three months. Then Steven came home drunk one night yelling, "I've fired the head-doctor. I'm sick of his damn prying questions." I'll never forget the moment. I was peeling potatoes, and suddenly I though, 'All you've got to do is take this knife and stab him. Just a few stabs and it would be all over.'

Somehow I managed to control myself. And the next morning I called the psychiatrist and asked his advice. He gave me a telephone number to call. 'It's our local Alcoholism Information Centre,' he said. 'Maybe they can help you.' They did —they saved my marriage.

At the Centre I was turned over to a psychiatric caseworker who was to be my counsellor. I gave her the history of Steve's case, and told her he had once tried Alcoholics Anonymous, which had helped so many, only to abandon it in much the same manner he'd just given up psychiatry. Was he beyond aid? She said no alcoholic is beyond aid, but that we were getting ahead of ourselves. Before worrying about Steve, we had to consider my problems. Until I solved them there was little chance of Steve's ever responding to treatment.

To begin with, I had to realize that I myself was sick. Over the years, the strains and tensions set up by Steve's drinking had made me an emotionally disturbed, overwrought woman who was no longer capable of thinking or acting realistically. Until my emotional balance was restored, it was impossible to help Steve.

Furthermore, I had a block, perhaps the most important single factor in preventing me from giving him the help he needed. I was only giving lip-service to the idea that Steve's compulsive drinking was a disease, while emotionally rejecting it. I treated him as if he were drinking deliberately and willfully. As a result my efforts were so wide of the mark that, if we thought of Steve's illness in terms of a sore toe, I could be accused of trying to step on it.

I had to learn to tread lightly in the region of his toe, for it was a very painful one. He was suffering from feelings of guilt, remorse, and self-hate incomprehensible to a non-alcoholic. Alcohol was the crutch Steve used to support a crippled ego. And anyone who tried to take it from him would be met with grim defiance.

That was why my Home Treatment hadn't worked. I had reminded him of his failures, made him hate himself even more. I had increased his sense of guilt and whittled away at his self-esteem. When I'd taken over his role as head of the house, I'd undercut his manhood and his self-confidence at a time when they badly needed building up.

At this point, Steve and I hardly ever spoke to each other except in bitterness. My son was living in fear of his father, while my daughter seemed to take a cruel delight in calling her dad a 'no-good bum.' Well, perhaps then I could understand why alcoholism is called the 'Family Illness.' Steve's sickness had made us all emotionally unhealthy. Our home atmosphere was enough to drive any man to drink, let alone, an alcoholic. How could I expect Steve to come home sober to face a family that met him with fear, disgust, shame, even hatred?

He would continue to turn to his bottle as long as he had to breathe such an atmosphere. It was his only

defense. Now it was up to me to create a new climate in my home, one that would make Steve feel wanted rather than rejected. Everything hinged on this. I had to stop driving Steve to drink, had to begin giving him support and understanding. He'd never seek help, much less respond to treatment, until he had been given a reason to want to stop drinking. And there was no better way to do this than to convince him that there was still a place for him in the family circle.

It wasn't going to be easy, the caseworker warned me. It meant an almost complete change in my behavior and my attitudes. She thought I should come to her regularly for counselling, and also enroll in the weekly group meetings the Centre held for wives of alcoholics. I agreed immediately.

In the long weeks that followed under the gentle guidance of my counsellor and with the sometimes sharp-tongued advice, support, and criticism of the other wives in the group, I changed. I could think clearly for the first time in years, and I even began to react like a normal being. What's more, once I understood something about the fears that were driving Steve to drink, it was possible for me to feel in my heart that he was sick.

This made a world of difference, for it drained me of all my hurt and anger. Steve's continued drinking was still a trial to bear, but it was a trial of love, not bitter injustice. I had nothing to hold against him any more.

So I slowly acquired compassion and understanding, with the inevitable result that my attitudes toward Steve and his drinking softened. And the change in me brought on changes at home.

Doug and Ann were the first to reflect them. Often before I'd explained to them that their father was a sick man. But because I'd never fully believed it myself, I'd never convinced them. Now that I was sincere, I succeeded.

With Steve, I stopped treating him like a delinquent child. I did everything I could to restore his dignity as head of the house. I made him make decisions. I stopped 'mothering' him excessively. And I asked for his help whenever possible, trying to show him that I needed him—as I did, or I'd have left him long since.

I tried to draw him nearer to me. This posed unexpected problems. For example, I hadn't given Steve a homecoming kiss in years, since the night he angrily accused me of kissing him just to check up on his breath. What was I to do now? I finally got up the courage to try, thankfully on a night he came home sober. When Steve recovered from his shock he said, almost humbly, 'Thanks. I've missed that.'

Above all, I never mentioned his drinking unless he brought the subject up first. And when he did bring it up, I tried my best to make him see that I'd come to understand what he was going through, and tried desperately to pass on to him something of what I'd learned about alcoholism.

In short, I tried with all my heart to put into practice the principles I'd learned at the Centre. And eventually they had a therapeutic effect on Steve, just as I'd been told they would.

Half jokingly, my counsellor had offered to bet me that Steve would show an interest in the Centre within six months of the time I succeeded in creating a healthy atmosphere at home. Well, I went to the Centre on May 7, 1958. Five months later, Steve sat on the edge of his bed one morning after a particularly bad

night, and said to me very quietly, 'You know, you haven't nagged me for months. Don't think I haven't appreciated it. You've been wonderful. And here I go and pull something like last night on you. I'm beginning to think I'm nuts. Maybe I should talk to that woman you've been seeing. What's her number?'

I'd finally done my job—with outside help. And that, I think, is the lesson to be drawn for my story. To handle an alcoholic husband, you must have expert help and guidance. Without it—ignorant of the true nature of alcoholism, ill-advised by friends and relatives, and too emotionally upset yourself to make sense—you inevitably turn to the Home Treatment. And it never, never works.

When Steve went to the Centre he was referred to a doctor who placed him on Antabuse, under close medical supervision. This is a drug that makes you violently ill if you take a drink while it's in your system. The idea was to make it impossible for Steve to drink for a while, so he could clear his head of alcohol. Once he'd begun to think soberly, my counsellor went to work and, praise be, managed to get through to him. She suggested he try group therapy. He agreed, somewhat skeptically. And to his surprise and delight, it worked. Since then he's been sober for two glorious years.

How do we stand today? Steve's cure has changed everything. We're almost out of debt. Among other things, Ann is teaching her father to cha-cha. This past summer, Steve took Doug and three of his pals camping.

I have confidence in the future. For if Steve should ever slip, I think I'll know how to handle the situation. Thanks to the Centre, I've learned my lesson. Love is an alcoholic's greatest need.

ALCOHOL EDUCATION

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area of mental health. What is it in our society that breeds alcoholism? Why do people readily turn to chemicals for a solution to their problems?

In his book on mental health, Dr. D. L. Farnsworth suggests that the mental health in our schools has a great deal to do with emotional blocks to learning, and with how the teacher and the students interact. He asks the question whether we, as educators, regard the students as living, feeling, developing personalities with an infinite variety of approaches to the problem of attaining maturity, or do we regard them simply as willing or unwilling receptacles into which knowledge is to be poured. He asks whether we foster curiosity or rebellion. Are we intellectually honest with them in dealing with such controversial subjects as sex and alcohol?

One of the most important goals of prevention in this area, I believe, is to teach students to understand themselves, to recognize their limitations and their capacities, their shortcomings and their strong points—real life is not all peaches and cream, but a combination of good luck—bad luck, good health—ill health, ups and downs. It is immature not to recognize problems; it is immature to run away from problems; and it is immature to try to blot out these problems by means of chemicals.

The simple prayer that has become identified with Alcoholics Anonymous has much meaning in this context:

"God grant me the serenity to accept
the things I cannot change,
the courage to change the things I
can, and the wisdom to know the
difference."

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course of a year, the Italian family consumes a great deal of wine, but seldom did I see one who overindulged. Nor did drinking pose a great problem to the youngsters who grew up in those families. They simply accepted the views of the family. They used it, but rarely abused it.

The pattern is vastly different among American drinkers. Here the pattern is associated with having a good time, with having fun, with excitement, with prestige. Many adults believe that a party is a flop unless plenty of drinks are served. The American husband has forgotten how to be a host; instead, he has been reduced to the role of bartender. We are acutely conscious of status. The drinkers know which brands of whiskey and scotch are the most expensive. The modern host takes pride in setting these bottles before his company; it is a sign that he has arrived at an important place in society. Of course, this same man will vote against school levies and bonds because he says taxes are driving him to the poorhouse. Our view of drinking is that it is glamorous. Advertisements for alcoholic beverages portray people in splendid dress, sitting at ease in surroundings that cost $75,000 if it cost a penny. And the children see this and they think, "It takes a big shot to live like this." Or the kiddies see their parents going off to a party, carrying with them their alcohol, contained in attractive glass decanters, encased in genuine leather holders. And this tells the youngsters more about drinking patterns than all the words they hear in school, church or the home. Or consider further the wild mixture of drinks that we Americans experiment with. The English are horrified when they see what we do to good whiskey. My Italian friends stick to their red wine. But not Americans. We'll try anything—rum and coke, gin and lime juice, vodka and tomato juice. And again the children hear and they think, "Gee, it must be fun to mix all these things up and see what it tastes like."

Do you see what I'm saying? Our drinking habits represent a confused pattern. People drink because it's fun, because it's a big deal; they drink in attractive surroundings; they love new fads. Now this is the background against which our children formulate their own ideas about drinking. Seventy percent of adults do drink. In most of American society it is permissive to drink. And so the children are going to try drinking, too. But the ideas and attitudes the kids have about drinking are confused; some of their facts are erroneous. It is our task to help these youngsters do some straight thinking about the use of alcohol.

We can begin by giving them good facts about alcohol: what it is, how it works in the body, what the body does with alcohol. Some of our textbooks are simply in error in their presentation of these facts. Here is a quote from one high school text: "There is plenty of proof that alcohol is a narcotic poison." Another text states that "The alcohol habit grows similarly to the morphine habit." Now these statements are false. And what's more to the point, our youngsters know they are false. These are boys and girls who have taken a drink, or two, or three. It didn't poison them. They didn't develop any wild urge to drain a fifth or drink every day because of the drinks they took. When they hear statements like these in school, they simply disregard them. Nor does it do any good to tell the students that the use of alcohol will destroy their

health. They know their parents have been drinking for years and their health is fine. For like reasons, it is useless to tell them that only moral derelicts drink. Again, they see their folks drink and these are people they respect and love. Let's be honest with the youngsters. Good, accurate facts are available; use them, just as you would use the best facts at your disposal about physics. Use good films; use good textbooks. But look at these carefully and evaluate them.

Facts are not enough, however. We know, sometimes to our dismay, that more than mere facts go into the formulation of attitudes. We need an atmosphere in which young people can frankly discuss their ideas and concerns about the use of alcohol. All of us can do our part to encourage such discussions in school, church and the home.

Motivations for Drinking

In our discussions we can touch upon the reasons why people drink. Ask your class what significance teen-agers find in drinking. Most of the reasons given will fall into the area of pre-adult role playing. The kids drink because they think this is a big, important thing to do. We know how hard these youngsters struggle to be grown-up. Drinking is a part of that struggle. The other important motivation for teen-age drinking is tied in with feelings of inferiority, of shyness. Many boys have discovered that they feel more at ease at a dance after a beer or two. Fortified in this manner, they can ask a girl for a dance; they are not so self-conscious. In return, we can point out to such fellows that they haven't solved their problem; the beer did. And from there we can encourage them to solve these problems of self-consciousness for themselves, without resorting to artificial means or some kind of chemical comfort.

Not everyone drinks; 30% of our adult population does not. Not all our children will drink; some of them will have definite reasons for abstaining. Help them think these reasons through. Some people do not drink for religious reasons. Others refrain from drinking for health reasons, and this might be true for boys interested in athletics. For some, drinking is a luxury that they cannot afford.

Whatever the reasons may be, either for drinking or for abstaining, help the youngsters arrive at a mature decision based on sound facts.

By way of conclusion, let me point out that the greatest single danger in teen-age drinking is intoxication. And I don't just mean physical intoxication but a state in which they are presented with more stimulus and excitement than they can handle. One drink is not sufficient to make a 17-year-old boy drunk, but it can trigger a whole series of emotions that are more than he can handle. In such a state, he is a danger to himself and to others. Our teen-agers should be told this and the dangers of intoxication impressed upon them.

Perhaps this sounds like a big order. It is, but great advances can be made. We have a precedent for this kind of education. Our driver courses in high school are turning out many good young drivers. A skilled teacher helps the youngsters understand not only the facts about good driving, but also helps the student develop good attitudes. Our job in alcohol education is much the same. If we do our job well, our youngsters can develop mature attitudes toward alcohol that will prevent them from becoming problems to themselves or to society.

TEEN-AGERS are pre-adults. Teen-agers do not enjoy a subculture separate and apart from that about them. Teen-age behavior and drinking merely reflects the adult world. If we could but know ourselves our teen-ager would be readily understood. Teen-agers are people.

To know adult drinking is to know teen-age drinking, so let us begin at the beginning.

What is the substance that has aroused so many feelings? From a chemical point of view alcohol is a generic term which describes a specific class of compounds. Beverage alcohol is either ethyl or grain alcohol; its formula is C_2H_5O H.

When consumed by an individual alcohol is rapidly absorbed in the stomach, duodenum and small intestine, some perhaps reaching the large intestine. The speed of absorption varies according to a number of factors, the major one being the concentration of other substances in the gastrointestinal system at the time of ingestion. The blood concentration of the alcohol reaches its maximum 10 to 30 minutes later. It is absorbed rapidly, the average 150-pound man being able to completely oxidize about a fifth of a gallon of 100 proof beverage alcohol in about 24 hours, i.e. about one ounce per hour.

What does alcohol do to or for man? Basically, beverage alcohol is a depressant; an anesthetic which operates on the central nervous system, reducing perception, reaction time, tensions and anxieties. It is probably the effect on tensions and anxieties that accounts for the wide popularity of alcohol, for man lives in a world replete with stress.

The World Health Organization describes alcohol as "a drug whose pharmacological action is intermediate in kind and degree between addiction producing and habitforming drugs, so that compulsive craving and dependence can develop in those individuals whose make-up leads them to seek and find an escape in alcohol. With this substance the personal make-up is the determining factor but the pharmacological action plays a significant role; damage to the individual may develop, but does so in only a minority of users."

William James in *The Varieties of Religious Experiences* claims that "the sway of alcohol over mankind is

Teen-age drinking and behavior reflects the attitudes, habits and customs that are a part of the adult world.

TEEN-AGERS AND ALCOHOL

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unquestionably due to its power to stimulate the mystical faculties of human nature, usually crushed to earth by the cold facts and dry criticism of the sober hour . . . The drunken consciousness is one bit of the mystic consciousness, and our total opinions of it must find its place in our opinion of the larger whole."

The average person if asked why he drinks would probably give one or more of the following reasons: to keep warm, to cool off, to pep up, to relax, for the taste or smell, for medicine, or to comply with religious practices. The average non-drinker would probably give one or more of the following reasons for his abstinence: a belief that drinking is wrong, dislike of the taste, fear of loss of health or efficiency, bad experiences of someone else, past loss of control. Of the abstaining group, it is likely that one third did drink earlier in their lives.

Thus we have alcohol, used as a beverage for more than 6,000 years, praised and despised, enjoyed and condemned, but surviving through all.

Greenberg summarizes its physiological effects as follows:

"Habitual, heavy drinking produces—aside from its social, economic and moral havoc—serious and permanent bodily damage, mainly through . . . deficiencies, and other metabolic disturbances. There is no evidence that small or moderate amounts of alcohol are harmful. By improving blood circulation to the body surface, a little alcohol increases the appetite and eases tensions and irritations. It does not greatly affect normal blood pressure, but it does prevent the pressure from rising during anxiety. Alcohol certainly does not stimulate thought, but it may relieve worry."

How many people drink; how much, with what effect?

The American Institute of Public Opinion in 1945 began to query Americans 21 years of age and over regarding their drinking practices. They found that from 1945 through 1958 the percentage of the general population drinking has decreased steadily. In 1945, 67 per cent stated that they consumed alcoholic beverages; in 1946, 67 per cent; 1949, 58 per cent; 1950, 60 per cent; 1951, 59 per cent; 1952, 60 per cent; 1956, 60 per cent; 1957, 58 per cent; 1958, 55 per cent. When we add to these figures the findings of Riley and Warden and Maxwell we find that urban rates are higher than rural; males are more frequent users than females; the age bracket 21-29 shows the highest percentage of drinkers; the higher the income and/or educational level, the more likely the individual is to be a user; and finally, the percentage of users is highest among Jews, next among Roman Catholics, lowest among Protestants.

College Students

While there have been a number of studies of the drinking practices of college students, the Straus-Bacon study of 27 colleges and 17,000 students is so comprehensive no attempt will be made to include data from the other studies. Straus and Bacon report that 74 per cent of the college students studied used beverage alcohol. Again as with adults there were many variations. The following criteria were associated with a high percentage of users as compared to abstainers: (1) male vs. females; (2) high parental income vs. low parental income; (3) religious affiliation; Jewish, Roman Catholic, Protestant and Mormon; (4) urban vs. rural; and (5) religion.

Of male users, considerable importance was ascribed to the following reasons for drinking:

(1) To get high (12%);

(2) To get along better on dates (4%);

(3) As an aid in forgetting disappointments (4%);

(4) To relieve illness or physical discomfort (3%); and

(5) As an aid in averting crisis (1%).

Again these are clues to potential or present problem drinking.

Straus and Bacon interpret their findings as follows:

"The discrepancy between actual behavior and the message or norm presented by individuals or organizations attempting to initiate, maintain, or change behavior is of significance for teachers, ministers, parents, legislators . . . Often enough, perception of the discrepancy leads merely to condemnation of those not following the prescription, or to more intensive and extensive repetition of command or advice . . ." They suggest that persons in different sociological categories present different degrees of susceptibility to techniques for changing, modifying, initiating or blocking behavior. It is plain that advice for complete abstinence given uniformly to children of poor and wealthy parents, to Southern Negroes and to Jews, to those of Mediterranean and English backgrounds, is going to be received variously and to be effective in extremely different degrees."

Other significant findings are as follows: More than 90 per cent reported having received specific advice concerning the use of alcoholic beverages; nearly half indicated that this advice was to abstain. Among male students where no advice to abstain was given, 82 per cent drank; where parents recommended abstention, 60 per cent drank; when the church (not parents) recommended abstinence 84 per cent drank; and where teachers (not parents or church) recommended non-drinking 90 per cent were users. The same trend but with a lower percentage of users was found among female students. The findings suggest that negative sanctions operating in a vacuum are of doubtful value.

Again, questionable motives for drinking were found.

A series of studies of teen-age drinking have been conducted for high schools in a suburb of the District of Columbia in 1941, 1945, and 1947; in Utah in 1951 and 1958; in Nassau County, New York in 1953; in Wisconsin in 1956; Kansas in 1956; and finally, in Michigan in 1958. Approximately 16,000 students are represented by these studies. It is reasonable to believe sufficient and representative data is available to make adequate generalizations.

High School Students

The most striking findings from the high school student drinking studies are these: (1) the typical American teen-ager is a user of alcohol beverages; (2) there are great regional variations; (3) teen-agers are moderate users; (4) they are usually introduced to alcohol by their parents in their own homes; (5) from age 14 through 18 the percentage of users increases steadily; (6) laws relating to teen-age drinking have little relation to drinking practice; (7) if an individual is ever going to drink, he will very likely have begun prior to graduation from high school; (8) teen-age drinking attitudes and customs correlate with the same variables noted in the adult population, socio-economic class, religious affiliation, and drinking practices of their parents.

Six per cent of the students report problems after drinking as follows: (1) heterosexual misconduct (by their own definition), (2) fighting, (3) overemotional, (4) accidents, and (5) talking too much.

Interestingly enough, this six per cent is about the same proportion of the general adult population who are alcoholics.

Five per cent of the students report having "passed out" from drinking, 20 per cent as having been ill, 17 per cent having been drunk and one-third as having been "high." Some report having used alcohol in a dependent manner or in direct conflict with the practices of their parents. Fourteen per cent of all students report drinking prior to attendance at parties, 21 per cent alone, 35 per cent whenever they get a chance; 13 per cent describe their first drinking experience as occurring in a car, and between one or five per cent had their first drink alone or with a stranger. In Kansas it was found that only three-quarters of the users were convinced that there was "nothing wrong with drinking on certain special occasions." Thus one-quarter of the users were uncertain or ambivalent about the validity of their drinking. This latter attitude—ambivalence—is a possible pre-condition to later problem drinking.

Sower interprets the findings of his investigation of teen-age drinking as follows:

(1) Students who view themselves as drinkers are more likely to perceive themselves as adults than as sub-adults or youth submissive to adult authority.

(2) They by and large disagree with adults in the school and community about the appropriateness of teen-age drinking.

(3) From the viewpoint of adults (many), drinking is an adult action, and no high school students are defined as adult.

(4) From the viewpoint of these students, they are sufficiently adult to decide for themselves to drink if they so desire.

(5) From our point of view this behavior is "premature playing of adult social roles."

(6) Yet they are drinking; this leads to the heart of the problem for some high school students.

(7) They eventually view themselves as adults and reject most if not all such youth roles as defined by adults.

(8) For this group their drinking becomes symbolic of something far more significant to teen-agers than merely how to fill leisure time.

(9) Essentially, drinking is a means of dissolving adolescent status and demonstrating adult status.

(10) Young people are leaving the adolescent world and entering the adult world, which now includes the uncontestable right to drink if they so desire.

(11) Anthropologically, the graduation party equals a "rite of passage" from adolescence to adulthood.

Realistic Goals

It should be rather clear by now that beverage alcohol is very much a part of our heritage, that our goals have to be devised within the reality of the present day world and that our task is not a single one. In closing, I am going to quote from my good friend John Pasciutti, Superman of Alcoholism Education in Vermont. Speaking of the job before us, John suggests that we must be involved with ". . . social conventions, personality, pain, tensions, cradle experiences, child rearing, feelings of belonging and feelings of adequacy. . . . The modern school, like the little red school house, has as its objectives the making of good, healthy, human personalities out of children who come to it. It is imperative that the churches, parents, communities, and the devoted, but humble, teaching profession all work together in an effort at building these healthy personalities."

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**Educational Division, Board of Alcohol Control;* Don Dancy, Educational Director; Parkway Office Building; Phone ALpine 3-7567.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone ALpine 4-2311.

BURLINGTON—

‡*Outpatient Clinic;* Alamance County Hospital; Hours: Wed., 9:00 a.m.-4:00 p.m.

BUTNER—

‡*Aftercare Clinic;* John Umstead Hospital; Hours: Mon.-Fri., 9:00 a.m.-4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Dr. D. D. Carroll, Director; 102 Laurel Hill Rd.

CHARLOTTE—

**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: FRanklin 5-5521.

‡*Mecklenburg Aftercare Clinic;* 1200 Blythe Blvd.; Hours: Mon.-Fri., 8:00 a.m.-5:00p.m.

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CONCORD—

†*Cabarrus County Health Department;* Phone: STate 2-4121.

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†*Gaston County Health Department;* Phone: UNiversity 4-4331.

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**Wayne Council on Alcoholism;* A. T. Griffin, Jr., Executive Director; P. O. Box 1320; Phone: 734-0541.

GREENSBORO—

**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone: 275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: BRoadway 3-9426.

†*Family Service Agency;* 1301 N. Elm St.

‡*Outpatient Clinic;* 300 E. Northwood St.; Hours: Mon. and Thurs., 5:00-10:00 p.m.

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†*Pitt County Mental Health Clinic;* Pitt County Health Department, P. O. Box 584; Phone: PLaza 2-7151.

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HIGH POINT—

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JAMESTOWN—

**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 883-2794.

LAURINBURG—

**Scotland County Citizens Committee on Alcoholism;* M. L. Walters, Executive Secretary; 308 State Bank Bldg.; Phone: 276-2209.

MORGANTON—

‡*Aftercare Clinic;* Broughton Hospital; Hours: Mon.-Fri., 2:00-4:00 p.m.

NEW BERN—

**Craven County Council on Alcoholism;* Gray Wheeler, Executive Secretary; 409½ Broad St., P. O. Box 1466; Phone: 637-5719.

NEWTON—

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‡*Aftercare Clinic;* Dorothea Dix Hospital, S. Boylan Ave.; Mrs. Dorothy Ferrell, Psychiatric Social Worker; Phone: TEmple 2-7581, Ext. 421; Hours: Mon.-Fri., 1:00-4:00 p.m.

‡*Aftercare Clinic;* Rex Hospital; Hours: Mon., a.m. and p.m.; Wed., p.m.; Thurs. and Fri., a.m.

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**Rockingham County Committee on Alcoholism*; Mrs. Anne Wall, Executive Secretary; 225 W. Morehead St., P. O. Box 355; Phone: DIckens 9-4369.

SALISBURY—

**Educational Division, Rowan County ABC Board*; Peter Cooper, Director; P. O. Box 114; Phone: 633-1641.

†*Rowan County Mental Health Clinic;* Community Bldg., Main and Council Sts.; Phone: MElrose 3-3616.

SANFORD—

†*Mental Health Clinic of Sanford and Lee County, Inc.;* 106 W. Main St. P. O. Box 2428; Phone 775-4129 or 755-4130.

SHELBY—

†*Cleveland County Mental Health Clinic;* 409 E. Marion St.; Phone: 482-3801.

SOUTHERN PINES—

**Moore County Alcoholic Education Committee;* Rev. Martin Caldwell, Director; P. O. Box 1098; Phone: OXford 2-3171.

WILMINGTON—

†*Mental Health Center of Wilmington and New Hanover County;* 1013 Rankin St.; Phone: ROger 2-8294.

**New Hanover County Council on Alcoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; Phone: 736-7732.

WILSON—

‡*Aftercare Clinic;* Encas Station; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson County Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

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